IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1977

No. 77-1714

FRANKFORD HOSPITAL, *Petitioner*

v.

BLUE CROSS OF GREATER PHILADELPHIA, *Respondent*

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

Samuel P. Lavine
John P. Quinn
Carl T. Bogus
STEINBERG, GREENSTEIN, GORELICK & PRICE
Attorneys for Petitioner

818 Widener Building
1339 Chestnut Street
Philadelphia, Pa. 19107

THE LEGAL INTELLIGENCER, 66 NORTH JUNIPER STREET, PHILA., PA. 19107 (215) 561-4850

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Petitioner prays that a Writ of Certiorari issue to review the judgment of the United States Court of Appeals for the Third Circuit, entered in the above entitled case on May 2, 1977.

OPINIONS BELOW

The opinion issued on June 6, 1976, by the United States District Court for the Eastern District of Pennsylvania, printed in the Appendix hereto, is reported at 417 F. Supp. 1104. The opinion issued on May 2, 1977, by the United States Court of Appeals for the Third Circuit, also printed in the Appendix, is not yet reported.

JURISDICTION

The judgment of the United States Court of Appeals for the Third Circuit was entered on May 2, 1977. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

QUESTIONS PRESENTED

The McCarran-Ferguson Act, 15 U.S.C. §1011 et seq., provides that the federal antitrust laws shall not apply to the business of insurance with the exception of "any agreement to boycott, coercion, or intimidation," which continue to be subject to federal antitrust regulation. The questions presented for review are:

1. Whether, with respect to the McCarran-Ferguson Act, the terms "boycott," "coercion," and "intimidation" are to be given their usual meanings or whether they are to be construed as referring only to boycotts and other coercive acts that are directed against insurance companies and agents by other insurance companies and agents;

2. Whether Blue Cross' discriminatory benefit scheme, under which its subscribers are heavily penalized for selecting a hospital which has not signed a contract with Blue Cross (a "non-member" hospital) constitutes a boycott or an attempt to boycott non-member hospitals;

3. Whether Blue Cross has used its monopoly power to coerce hospitals into contracts that give Blue Cross large discounts for medical services rendered to its subscribers and which are unreasonable in other respects as well.

STATUTES INVOLVED

The statutes involved are the Sherman Act, §§1 and 2 (15 U.S.C. §§1 and 2), and the McCarran-Ferguson Act, 15 U.S.C. §1011 et seq., and particularly §3 of that Act which reads:

> §1013. Suspension until June 30, 1948, of application of certain Federal laws; Sherman Antitrust Act applicable to agreements to, or acts of, boycott, coercion, or intimidation
>
> (a) Until June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, and the Act of June 19, 1936, known as the Robinson-Patman Anti-Discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.
>
> (b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

STATEMENT OF THE CASE

Blue Cross of Greater Philadelphia ("Blue Cross") is one of 74 members, or "plans" as they are called, of the Blue Cross Association, headquartered in Chicago, Illinois. However, it is important to note at the outset that each of these plans is, for all relevant purposes, autonomous; each writes its own contracts with both subscribers and hospitals. When we refer to the Blue Cross arrangement with subscribers or hospitals, therefore, we shall be referring only to Blue Cross of Greater Philadelphia and its unique contracts and relationships.

Frankford Hospital ("Frankford") is a 213 bed, nonprofit general community hospital located in northeast Philadelphia. It commenced this action on September 4, 1974, on behalf of itself and all other nonprofit hospitals that were Blue Cross "member hospitals"—i.e. had a contract with Blue Cross—over the preceding four years. Frankford complained of antitrust violations, and jurisdiction in the district court was based on sections 4 and 16 of the Clayton Act, 15 U.S.C. §§15 and 26. Class action certification was granted pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure. On the eve of trial—and after nearly two years of extensive discovery and procedural skirmishing—the district court granted summary judgment in favor of Blue Cross, and in a three-paragraph opinion the United States Court of Appeals for the Third Circuit affirmed.

As did virtually all nonprofit hospitals in the greater Philadelphia area, Frankford signed Blue Cross contracts in 1967 and 1971 after long and acrimonious negotiations. When the 1971 contracts expired in the Summer of 1974, Philadelphia area hospitals split into two groups. Frankford and about forty hospitals refused to sign a new con-

tract on the terms proposed by Blue Cross while another group signed new contracts.[1]

Blue Cross is not an insurance company in the classic sense. A standard insurance company agrees to reimburse its policyholders for their hospital bills. However, Blue Cross does not generally reimburse its subscribers for hospital bills incurred; instead, in return for their premiums, Blue Cross promises its subscribers that they may be treated at Blue Cross member hospitals without further charge (except for the deductible amount in the subscribers' contracts and charges for personal amenities such as for a private room or television). Blue Cross enters into separate contracts with hospitals under which the hospitals agree to look exclusively to Blue Cross for payment of services to Blue Cross patients. But, Blue Cross does not agree to pay hospital charges. It employs a "cost-reimbursement" system based on the costs of operating a hospital, as determined on audit. Under this system Blue Cross pays its proportionate share of some hospital costs, but it pays nothing at all toward other real hospital expenses,[2] leaving the financial burden of those expenses entirely upon other patients.

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1. On August 2, 1975, the Pennsylvania legislature enacted Act 94 of 1975 (40 Pa. C.S.A. §6124c) which retroactively reinstated the 1971 contracts between Blue Cross and those hospitals, including Frankford, which did not sign new contracts. The constitutionality of that legislation was challenged but upheld in *Guest v. Fitzpatrick*, 409 F. Supp. 818 (E.D. Pa. 1976), *prob. juris. noted*, 50 L. Ed. 73 (1977). In 1977 Frankford and other hospitals finally acquiesced and signed new Blue Cross contracts.

2. Most notably, Blue Cross refuses to pay anything toward free care, bad debt, and operating growth need. Free care and bad debt result from care to persons who do not or cannot pay their hospital bills; these costs are highest among the urban hospitals. Operating growth need results from the dual forces of inflation and escalating medical technology. Hospital administrators testified that all of these constitute real expenses for which hospitals must receive money.

The effect of excluding these real expenses is that Blue Cross pays substantially less than its proportionate share of hospital expenses. The hospitals, in turn, are forced to inflate their charges to try to recover sufficient funds from patients who pay their own bills and from insurance companies that indemnify them. This creates a wide gap between what Blue Cross and others pay for the same hospital service. At one hospital,[3] private paying patients constitute 14% of the total patient population but supply 27% of the hospital's revenue. Moreover, hospitals are not always able to pass Blue Cross' share of expense on to the private paying sector. There are approximately 2,400,000 Blue Cross subscribers; that number represents about 62% of the combined populations of Philadelphia and the four adjacent Pennsylvania counties. Still others are covered by Medicare and Medicaid which pay on the basis of government mandated formulae rather than hospital charges, while others, of course, fall into free care and bad debt categories. The private paying sector is often too small to subsidize these costs alone; therefore, many hospitals are losing large sums of money each year and are on the brink of financial disaster.

Frankford alleges that neither it nor the other hospitals voluntarily contracted with Blue Cross on these terms, but were rather compelled into becoming Blue Cross member hospitals by means of subtle yet effective boycott. The boycott springs from the contracts between Blue Cross and its subscribers. Under these contracts, a subscriber who is treated at a Blue Cross member hospital is relieved of all responsibility for his or her hospital bill (except, as previously mentioned, for deductibles and amenities). A subscriber who selects a non-member hospital is personally responsible for the hospital bill and is entitled to an indemnity (cash) benefit from Blue Cross. However, these

3. This is the Hospital of the Medical College of Pennsylvania.

indemnity benefits are miniscule and bear no reasonable relationship to hospital costs; for example, some subscribers receive only $50 for their first day of hospitalization and $25 for each subsequent day, while average hospital charges in Philadelphia exceed $200 per day. (A3) Subscribers, therefore, pay a heavy penalty for selecting non-member hospitals, penalties so excessive that for many families choosing a non-member hospital, even for a moderate stay, would result in financial ruin. Most Blue Cross subscribers—representing 62% of the area population—therefore shun non-member hospitals. It is this discriminatory benefit scheme that Frankford alleges constitutes a boycott.

In conjunction with the boycott, Blue Cross uses other coercive mechanisms to force hospitals into signing contracts. Most notable is Blue Cross' refusal to honor assignment of benefits. Assignments of benefits from insured patients are important to hospitals. A hospital is virtually guaranteed payment if it may submit its bills directly to responsible insurers; however, it is a sad reality that not everyone is reliable and a hospital often receives nothing when an indemnity benefit is sent to the patient rather than the hospital. An insurance company which is obligated to pay a sum as a result of a hospital bill incurred by its policyholder has no legitimate reason in refusing to honor an assignment of benefit from the policyholder to the hospital. Frankford argues that Blue Cross' only possible motive in so refusing is to minimize money actually received by non-member hospitals and to further coerce them into becoming members.

REASONS FOR GRANTING THE WRIT

The core issue in this case concerns a question of interpretation of the McCarran-Ferguson Act, 15 U.S.C. §1011, et seq. That Act, *inter alia*, generally exempts the business of insurance from federal antitrust regulation; however, section 1013(b) provides that acts or agreements to boycott, coerce or intimidate shall continue to be subject to the antitrust laws. "The crux of the case is not what Blue Cross has done," wrote the district court, "but how its actions should be characterized in the context of section 1013(b)." (A11) Concluding that, "In this context, the terms, boycott, coercion, and intimidation, cannot be given as broad a meaning as they might have if used to define unreasonable restraint of trade," the court held that Blue Cross' actions did not fall within the section 1013(b) "even if they might be unreasonable restraints of trade. . . ." (A11-12, A17-18)

The circuit courts of appeals are split as to how the words "boycott," "coercion," and "intimidation" should be construed for purposes of the McCarran-Ferguson Act. When it affirmed the district court's decision in the instant case, the Third Circuit implicitly joined the Fifth and Ninth Circuits in the view that those words are to be read as referring only to boycotts and other coercive acts which are directed against insurance companies and their agents by other insurance companies and their agents. *See Meicler v. Aetna Casualty & Surety Co.*, 506 F.2d 732, 734-35 (5th Cir. 1975), and *Addrisi v. Equitable Life Assurance Society*, 503 F.2d 725, 728-29 (9th Cir. 1974), *cert. denied*, 420 U.S. 929 (1975). *But see Battle v. Liberty National Life Insurance Co.*, 493 F.2d 39, 51 (5th Cir. 1974), *cert. denied*, 419 U.S. 1110 (1975). On the other hand, the First, Second, Fourth, and District of Columbia Circuits have held that the terms are to be given the same meaning for purposes of the McCarran-Ferguson Act as they generally and commonly are given. *See Barry v. St. Paul Fire & Marine Insurance Co.*, 1977-1 CCH Trade Cases ¶61, 431, — F.2d — (1st Cir., May 16, 1977); *Monarch Life Insurance Co. v. Loyal Protective Life Insurance Co.*, 326 F.2d 841, 846 (2nd Cir. 1963), *cert. denied*, 376 U.S. 952 (1964); *Ballard v. Blue Shield*, 543 F.2d 1075, 1078 (4th Cir. 1976); and *Proctor v. State Farm Mutual Automobile Insurance Co.*, 1977-1 CCH Trade Cases ¶61,481, — F.2d — (D.C. Cir. June 17, 1977). *See also Al Barnett & Son, Inc. v. Outboard Marine Co.*, 64 F.R.D. 35, 43 (S.D.N.Y. 1974); and *Cooperative DeSeguros Multiples De Puerto Rico v. San Juan*, 294 F. Supp. 627, 628 (D.P.R. 1968).

The story of how the Third, Fifth, and Ninth Circuits adopted the unusual and limited definitions of "boycott" and "coercion" is an interesting study of imprecise language resulting in error, and the error being repeated and compounded. The seed of confusion was first planted in *Transnational Life Insurance Co. v. Roseland*, 261 F. Supp. 12 (D. Ore. 1966). The district judge in pure *dicta* declared, in one portion of his opinion, that the legislative history of the McCarran-Ferguson Act showed that, "the boycott, coercion and intimidation exception, was placed in the legislation to protect insurance agents from the issuance by insurance companies of a black-list. . . ." *Id.* at 26. Although there is no reason to believe it was so intended by the court, many infer from this language that Congress was concerned *only* with black-lists. That inference is completely unwarranted. First, the only source cited by the court was a single page of the Congressional Record, to wit 91 Cong. Record 1087 (79th Congress, 1st Session); but there is nothing on this page—or anywhere in the entire legislative history— to support that proposition. Moreover, only one page later the *Transnational* court, again referring to the McCarran-Ferguson Act, wrote: "The word 'boycott' has a well-known meaning. Congress is presumed to have used that word in its usual significance and in accordance with common understanding." *Id.* at 27-28.

Eight years later another district court, citing *Transnational*, held that section 1013(b) "was designed *primar-*

ily to deal with conspiracies or combinations among insurance companies and agents for the purpose of boycotting or refusing to deal with other insurance companies and agents." *Meicler v. Aetna Casualty and Surety Co.*, 372 F. Supp. 509, 513-14 (S.D. Tex. 1974) (emphasis added). Within a few months both the Ninth and Fifth Circuits—each citing both *Transnational* and the district court in *Meicler*, but overlooking the word *primarily*—held that section 1013(b) *only* referred to acts by insurance companies and agents against other insurance companies and agents. *Addrisi v. Equitable Life Assurance Society, supra*, at 728-29; *Meicler v. Aetna Casualty and Surety Co.*, 506 F.2d 732, 734 (5th Cir. 1975). Now the Third Circuit has followed suit, and the precedent for this view—although resting on the most feeble of foundations—is substantial.

CONCLUSION

This issue of interpretation of the McCarran-Ferguson Act is of great importance. As one commentator has noted, under the view adopted by the Third, Fifth, and Ninth Circuits the only private plaintiffs who may invoke section 1013(b) are insurance companies; consumers and others are effectively barred from bringing suit. *See* Comment, "The McCarran-Ferguson Act: A Time for Procompetitive Reform," 29 *Vanderbilt L. Rev.* 1271 (1976). This Court's review is necessary to resolve a split among the circuits on this issue. We, therefore, respectfully request that our petition be granted.

Respectfully submitted,

STEINBERG, GREENSTEIN, GORELICK & PRICE

By:
Samuel P. Lavine
John P. Quinn
Carl T. Bogus
Attorneys for Petitioner

818 Widener Building
1339 Chestnut Street
Philadelphia, Pennsylvania 19107

CERTIFICATE OF SERVICE

I certify that the foregoing Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit was served upon all interested parties on July 29, 1977, by depositing three copies in a United States mail box, with first class postage prepaid, addressed as follows:

Raymond T. Cullen, Jr., Esq.
MORGAN, LEWIS & BOCKIUS
2100 The Fidelity Building
123 South Broad Street
Philadelphia, Pa. 19109

Blue Cross of Greater Philadelphia
1333 Chestnut Street
Philadelphia, Pa. 19107
Attention: Legal Department

James H. Stewart, Jr., Esq.
NAUMAN, SMITH, SHISSLER & HALL
6 North Third Street
Harrisburg, Pa. 17108

John P. Quinn

IN THE
UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action
No. 74-2281

FRANKFORD HOSPITAL

v.

BLUE CROSS OF GREATER PHILADELPHIA

Memorandum and Order

June 8, 1976.

NEWCOMER, *J.*

This suit grows out of a controversy about the criteria for reimbursing hospitals for services rendered to Blue Cross subscribers. Frankford Hospital, individually, seeks damages and injunctive relief against Blue Cross of Greater Philadelphia on the ground that it has violated the federal antitrust laws.[1] On September 25, 1975, this court certified plaintiff the representative—for the purpose of injunctive relief only—of a class consisting of all Pennsylvania nonprofit hospitals, clinics, and medical centers that have had a hospital contract with defendant in force at any time during the period September 4, 1970 to September 4, 1974. Extensive discovery followed. At its com-

1. Sherman Act §§1 and 2, 15 U.S.C. §§1 and 2. Plaintiff also alleges a pendent claim under Pennsylvania common law doctrines outlawing certain restraints of trade.

pletion defendant filed a motion for summary judgment. For the reasons stated below this motion will be granted.

FACTS NOT IN DISPUTE

Defendant, Blue Cross of Greater Philadelphia, (hereinafter Blue Cross) is a nonprofit corporation which operates hospital plans whereby its subscribers are provided hospitalization and related health services. Defendant is certified to do business in the Commonwealth by the Pennsylvania Insurance Department.[2] Defendant, a member of the Blue Cross Association, headquartered in Chicago, Illinois, is the oldest of five Blue Cross plans in Pennsylvania, and has approximately 2,400,000 subscribers in the Philadelphia area.

Blue Cross is not an insurer in the classic sense of that term. In its contracts with subscribers it agrees to furnish them needed health care services in return for premiums paid by them, or on their behalf (e.g. by employers). In order to carry out these obligations Blue Cross contracts with eligible hospitals.[3] In a typical situation, a subscriber goes to a member hospital,[4] presents his or her Blue Cross card, and receives health care services and the hospital sends the bill directly to Blue Cross. On the other hand, a patient insured under a traditional, private health insurance policy is billed for the services he receives and is entitled to receive cash indemnification by his insurer in an amount determined by his particular policy.

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2. At all times material to this action, Blue Cross existed and operated pursuant to the Nonprofit Hospital Plan Act, Act of June 21, 1937, P.L. 1988, §1 *et seq.*, 40 P.S. §1401 *et seq.*, as amended by the Act of November 15, 1972, P.L. 1063, No. 271, §6101 *et seq.*, 40 Pa. C.S.A. §6101 *et seq.* Certification of nonprofit hospital plans is provided for in 40 Pa. C.S.A. §6102.

3. As defined in 40 Pa. C.S.A. §6121.

4. Member hospitals are those which have contracts with Blue Cross.

Some of Blue Cross' subscriber agreements include indemnification provisions together with service benefit provisions. The indemnity clause comes into play when a subscriber receives care from a non-member hospital. Under most plans, Blue Cross' obligation is a relatively small fraction of the total charge for the service. For example, a subscriber may collect fifty dollars for the first day of hospitalization and twenty-five dollars for each subsequent day while the hospital's charge exceeds two hundred dollars per day. Blue Cross' role as an indemnity insurer of health care bills is relatively modest, compared to its service benefits business. Apparently, Blue Cross could—as a legal, if not a practical matter—refuse to underwrite any indemnity agreements.

Both the rates Blue Cross charges to subscribers and its rates of payments to hospitals must be approved in advance by the Insurance Department before they can go into effect. 40 Pa. C.S.A. §6124. At all times material to this action, the Pennsylvania Insurance Department has aggressively regulated Blue Cross' contractual relationships with subscribers and with hospitals. Prior to 1967, there were at least six different agreements between Blue Cross and various hospitals in the Philadelphia area. The Department instructed Blue Cross to develop a uniform contract. It particularly stressed that this contract should include the cost accounting principles upon which reimbursement under the federal Medicare Program was based. At the end of 1967, defendant submitted a proposed uniform cost contract between Blue Cross and Philadelphia area hospitals. The Insurance Commissioner, David O. Maxwell, disapproved it. In his notice of disapproval the Commissioner stated, *inter alia*, that Blue Cross should neither have to pay any portion of the hospitals' unreimbursed outpatient cost, nor to pay for depreciation or for miscellaneous unidentified costs under formulas which did not include specific incentives to hospitals to control

costs.[5] Mr. Maxwell's successors—Commissioners George F. Reed, Herbert S. Denenberg, and William J. Sheppard—adhered to the position that any contract between Blue Cross and Philadelphia area hospitals must include quality controls and ceilings on total cost reimbursement.[6]

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5. "Section 1-11 of Exhibit A provides for the allowance of certain unreimbursed outpatient costs. [This results from the rendering of services to persons who are not Blue Cross subscribers and who do not fully pay their hospital bills.] The basis of payment is, generally, the ratio of Blue Cross inpatient days to total inpatient days times outpatient costs for which the hospital has not been reimbursed from any source. Blue Cross would of course continue to pay for outpatient costs incurred by its subscribers."

"... It can therefore truthfully be described as an involuntary contribution by Blue Cross subscribers to the maintenance of emergency and clinical outpatient services."

* * *

"In my opinion, the maintenance of these essential facilities is a community responsibility, including federal, state and local governments as well as eleemosynary institutions and the public. It is not fair to shift that part of the burden which the community is neglecting to bear to Blue Cross subscribers without their consent and in accordance with a method of calculation largely unrelated to the cost to the hospital of proving [*sic*] outpatient services." Letter to Mr. Thomas F. Manley, President, Blue Cross of Greater Philadelphia, from Insurance Commissioner, David Maxwell (undated), Exhibit E to Affidavit of Bruce Taylor, President, Blue Cross of Greater Philadelphia, pp. 8-9.

6. In a letter to Blue Cross dated November 6, 1973, Insurance Commissioner Denenberg made the following comments about "free care":

> "This department cannot and will not approve the submitted cost-plus factor. I draw your attention to several basic reasons.
>
> "First, free care, the alleged cause of the plus factor, is not a cost connected with Blue Cross coverage . . . Blue Cross cannot pay for services outside of Blue Cross coverage. In short, Blue Cross, itself a nonprofit corporation, is not authorized to make contributions or gifts to hospitals in recognition of free services which may have been provided to the community. . . ."
>
> * * *
>
> "Sixth, the provisions and financing of free care service is a community problem. Costs of free care should be shared by the entire community through appropriations from government funds or otherwise." Exhibit M to Affidavit of Bruce Taylor, pp. 1-3.

After Commissioner Maxwell's rejection of the 1967 proposed Uniform Cost Contract, Blue Cross resumed negotiations with the hospitals and a new agreement[7] was reached by them and subsequently approved by the Commissioner. In 1971, Blue Cross resubmitted to the Pennsylvania Insurance Department for its approval a request for increases in rates charged to subscribers. Commissioner Denenberg's denial of the request sparked new, intensive negotiations between Blue Cross and the hospitals (which were represented in the negotiations by the Delaware Valley Hospital Counsel, hereinafter DVHC). The Commissioner attended many of the negotiating sessions. These efforts resulted in the Hospital Agreement of 1971, the terms of which reflected Commissioner Denenberg's negotiating guidelines.

Negotiations to reach agreement on a contract to succeed the 1971 Agreement commenced in March 1973. The negotiations, however, were not very successful, and before they were completed the 1971 Agreement expired. At this juncture the hospitals split ranks. In September, 1974, a number of the DVHC-represented hospitals became non-member hospitals. A number of other DVHC-represented hospitals, including the Philadelphia medical school hospitals, agreed with Blue Cross to extend the terms of the 1971 Agreement during the pendency of negotiations. In November, 1974, a number of Philadelphia hospitals reached agreement with Blue Cross on a contract. The Insurance Department approved it. This "1974

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7. Uniform Cost Contract—1967.

Agreement," which was retroactive to July 1, 1974, has been adhered to by all Philadelphia medical school hospitals (including one which did not actually sign it) and has been signed by some DVHC-represented hospitals and a number of community hospitals. Approximately 40 DVHC-represented hospitals refused to sign it.

The situation in which a large number of Philadelphia area health care facilities were not Blue Cross member hospitals created extreme problems for some subscribers in need of treatment. Both Blue Cross and the DVHC took out advertisements in newspapers at various times to inform the public about which hospitals were and were not under contract with Blue Cross to provide subscriber services. Some Blue Cross subscribers sought services in non-member hospitals either by mistake or because of the exigencies of medical emergencies, or for other reasons. It was an unhappy surprise to many when they learned that they were personally liable for substantial bills. On August 2, 1975, the Commonwealth of Pennsylvania enacted Act No. 94 of 1975, (40 P.S. §6124c). It reinstated, retroactively, the 1971 Hospital Agreement between Blue Cross and the non-member DVHC hospitals.[8] Under Act 94, the Blue Cross-hospital contracts may be terminated only after notice is first given to the Insurance Department which then can initiate various procedures during a "cooling off" period. Thirty-one hospitals sent notice to the Commissioner on and after August 25, 1975. In a decision rendered on May 21, 1976, Commissioner Sheppard ruled that he would not approve termination of the contractual relationship. At the same time, he set forth findings—which are comparable to guidelines—on the two remaining disputed areas in the negotiations. Clearly,

8. The constitutionality of this act was upheld by a three-judge court in Guest v. Fitzpatrick, Civil Action No. 75-2306 (E.D. Pa. Feb. 27, 1976), *appeal pending*. Judge Luongo dissented from the majority opinion of Judge Weiner and Circuit Judge Van Dusen.

state regulation of Blue Cross hospital contracts is still vigorous.[9]

Frankford Hospital contends that the 1967 and 1971 Agreements were unreasonable because under them Blue Cross paid for less than its proper share of the operating cost attributable to the treatment of Blue Cross subscribers. It claims that Blue Cross used its position of power and dominance to coerce the hospitals into signing the agreements. The "discount" on hospital services Blue Cross achieved under the contracts, as compared to what non-subscribers and their private insurers had to pay, was allegedly exploited to Blue Cross' advantage in further consolidating a monopoly in the health insurance market. Frankford Hospital asks the court to find that the 1971 Agreement is illegal, and to order defendant Blue Cross to offer to enter into a superceding agreement with members of the plaintiff class. Under the court-ordered contract Blue Cross would pay a prorated share of all operating costs, which included bad debts, free care, and "working capital requirements." Thus, although the plaintiff's theory of liability relates to events occurring in the four years prior to September 4, 1974, its prayer for relief rests on the

9. Commissioner Sheppard ordered that the termination of the contracts be suspended for ninety days. He observed that

> "the parties should be able to conclude [the negotiations] successfully within the very near future. . . ." Defendant Exhibit V, p. 3.

It would appear that Commissioner Sheppard, unlike some of his predecessors, is willing to approve a hospital contract under which Blue Cross bears some share of free care and bad debt costs. He stated:

> "[I]t is appropriate and proper for Blue Cross, on behalf of its subscribers, to bear an appropriate portion of certain free care and bad debt costs of member hospitals, after crediting against such free care and bad debt costs the resources available to hospitals for such purposes from sources other than patient payments." p. 2.

assumption that federal anti-trust law preempts the Commonwealth's Act 94, and this court is therefore obligated to declare unreasonable and unlawful the very contract which the legislature recently reinstated. Blue Cross' principal defense is that the McCarran-Ferguson Act expressly exempts from the federal antitrust laws the activities of which the plaintiff complains. It argues that federal law has, by its own terms, reserved these areas in the first instance for state regulation. Because our decision is firmly grounded on the McCarran-Ferguson Act, we do not discuss Blue Cross' defense based on *Parker v. Brown*, 317 U.S. 341 (1943).

MCCARRAN-FERGUSON ACT

Frankford Hospital has charged Blue Cross with restraining trade, in violation of Section 1 of the Sherman Act, 15 U.S.C. §1,[10] and with monopolizing and attempting to monopolize, in violation of Section 2 of that Act.[11] Blue Cross contends that it has not violated the precepts contained in these Sherman Act provisions and, in any case, these rules themselves are inapplicable to the actions herein challenged by the language of the McCarran-Ferguson Act, 15 U.S.C. §1011 *et seq.* Section 1012(b) provides in pertinent part:

> ". . . The Sherman Act . . . shall be applicable to the *business of insurance* to the extent that such business is not *regulated* by State Law." (emphasis supplied)

10. "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several states . . . is declared to be illegal. . . ."

11. "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several states . . . shall be deemed guilty of a misdemeanor . . ."

Excluded from the protection of this exemption are certain practices, namely—boycott, coercion or intimidation. Section 1013(b) of 15 U.S.C. provides:

> "Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce or intimidate, or any act of boycott, coercion or intimidation."

Substantially similar arguments to those advanced by plaintiff in this case were adjudicated in *Travelers Insurance Company v. Blue Cross of Western Pennsylvania*, 361 F. Supp. 774 (W.D. Pa. 1972), aff'd 481 F.2d 80 (3d Cir.) *cert. denied* 414 U.S. 1083 (1973). After a lengthy trial the district court dismissed plaintiff's complaint on the alternative grounds a) that the defendant could avail itself of the McCarran-Ferguson Act exemption because its contracts with hospitals were part of the business of insurance; these contracts were aggressively regulated by the Commonwealth of Pennsylvania; and the defendant had not, in connection with these contracts, accomplished an unreasonable restraint of trade through boycott, coercion, or intimidation as those terms are defined in 15 U.S.C. §1013(b); and b) assuming that the McCarran-Ferguson Act exemption did not apply, Blue Cross of Western Pennsylvania did not engage in any unlawful monopolization or restraint of trade. The Third Circuit affirmed on each of these grounds.

It is unnecessary to pass beyond the McCarran-Ferguson Act issue in order to decide the present motion. *Travelers* held that the rates Blue Cross of Western Pennsylvania charged its subscribers were so interrelated with the terms of Blue Cross' hospital contracts that the latter should be considered part of the business of insurance. 481 F.2d at 83. That conclusion was based on facts which were alike in all material respects to the undisputed facts

in this case. Moreover, the argument that *Travelers* should be distinguished from the instant case either because it involved a different Blue Cross plan and a different set of negotiations, or because a suit brought by a private insurance carrier presented the questions in a different light than a suit brought by a class of hospitals, was destroyed by the recent affirmance of *Doctors Hospital v. Blue Cross of Greater Philadelphia*, Civil Action No. 73-1057 (E.D. Pa. Aug. 13, 1975), *aff'd per curiam* No. 75-2166 (3d Cir. April 28, 1976). This narrows our task to making a determination whether there is any triable issue of material fact with respect to Frankford Hospital's assertions that Blue Cross of Greater Philadelphia has carried out acts of boycott, coercion or intimidation prohibited by 15 U.S.C. §1013(b).[12]

All doubts as to the existence of a genuine issue as to a material fact must be resolved against the party moving for summary judgment. *Lockhart v. Hoenstine*, 411 F.2d 455 (3d Cir. 1969), *cert. denied* 396 U.S. 941 (1970). At the same time, general allegations which do not show facts in detail and with precision are insufficient to prevent the award of summary judgment. *Tunnell v. Wiley*, 514 F.2d 971, 976 (3d Cir. 1975), *Engl v. Aetna Life Insurance Co.*, 139 F.2d 469, 473 (2d Cir. 1973). A party who resists summary judgment cannot hold back his evidence until the time of trial, *Robin Construction Co. v. United States*, 345 F.2d 610, 613 (3d Cir. 1965), and this is particularly true when the party has taken extensive discovery and has been given every reasonable opportunity to build a record

12. Because we conclude that §1013(b) is inapplicable, it is unnecessary for us to decide whether Blue Cross would be entitled to summary judgment on the ground that its activities in the Philadelphia area did not constitute unlawful monopolization or restraint of trade.

and to draw the court's attention to favorable selections from it.[13]

We find that no material facts are in dispute. The crux of this case is not what Blue Cross has done, but how its actions should be characterized, in the context of section 1013(b). Some hospital administrators have repeatedly asserted that Blue Cross has coerced their institutions to try to force them to sign contracts. Some hospitals have succumbed to the alleged coercion; others have not. Blue Cross does not deny that a hospital which changes from member to non-member status suffers adverse financial consequences, nor that the administrators of a hospital operating under either the 1971 or 1974 Agreement might believe that Blue Cross is not assuming a fair share of hospital costs. But defendant insists that nothing it is doing is coercion. To the contrary, it says it is doing the business that the legislature has intended it to do. In fact, some of the contractual provisions objected to by the plaintiff have been more or less frozen into Blue Cross' negotiating position by the decisions of the Insurance Department.

The terms, "boycott, coercion, or intimidation," must be interpreted with attention to the structure of the statutory provisions to which they are related. The Sherman Act proscribes practices which are monopolistic or are otherwise unreasonable restraints of trade. The McCarran-Ferguson Act creates an exemption from the Sherman Act provisions, but at the same time allows for an exception to the exemption. In this context, the terms, boycott, coercion, and intimidation, cannot be given as broad a meaning as they might have if used to define unreasonable

13. After oral argument on this motion the court granted the defendant's motion to strike plaintiff's affidavits on the ground that they failed to conform to the requirements of Rule 56(e). Plaintiff was given leave to submit additional affidavits and to file a supplemental brief pointing out pertinent portions of deposition testimony. Order of May 20, 1976.

restraint of trade. Otherwise, the Section 1013(b) exception would all but swallow up the body of the McCarran-Ferguson exemption. The exception must have been aimed at particular known practices in the insurance industry which Congress intended to outlaw irregardless [*sic*] of any efforts undertaken by the state to eliminate them through regulation. In *Meicler v. Aetna Casualty and Surety Co.*, 372 F. Supp. 509 (S.D. Texas 1974) *aff'd* 506 F.2d 732 (5th Cir. 1975), the district court stated:

> "It cannot be disputed that the terms boycott and coercion, as commonly defined, might be construed to encompass the type of activity attributed to defendants in the instant case. An examination of the legislative history of this section reveals, however, that Congress was seeking to regulate a rather narrow area of activity bearing no resemblance to the situation described in Plaintiffs' Complaint. Section 1013(b) was designed *primarily* to deal with conspiracies or combinations among insurance companies and agents for the purpose of boycotting or refusing to deal with other insurance companies and agents." (emphasis supplied) 372 F. Supp. at 513-514.[14]

Frankford Hospital's reliance on *Battle v. Liberty Life Insurance Company*, 493 F.2d 39 (5th Cir. 1974), *cert. denied*, 419 U.S. 1110 (1975), is misplaced. In that case the

14. We apply emphasis to the word "primarily" because we do not believe section 1013(b) should be strictly limited to the classic situation of insurance company blacklisting. In appropriate circumstances, the language of that provision would reach other practices which have the same purpose and effect as blacklisting or which are equally pernicious in violating the most fundamental notions of competition and fair play. In the instant case we are not presented with circumstances that require us to decide this issue. *But see* Addrisi v. Equitable Life Insurance Society, 503 F.2d 725 (9th Cir. 1975), *cert. denied*, 420 U.S. 947 (1975).

plaintiff was challenging activities of an insurance company (involving an arrangement with an additional party) that had *nothing to do with the issuing of insurance*. The court held that the McCarran-Ferguson Act exemption did not apply to the instant complaint. It explicitly distinguished *Travelers Insurance Company v. Blue Cross, supra*. In *dictum*, the court stated that even if the McCarran-Ferguson Act applied, the complaint would survive a motion to dismiss, because of allegations that brought Section 1013(b) into play. The complaint alleged, *inter alia*, that the defendants threatened to build funeral homes to compete with the plaintiffs' businesses; threatened physical violence against the plaintiffs and their agents; and threatened to cancel insurance contracts. Frankford Hospital has not alleged threats of physical violence, or threats to build competing hospitals, by Blue Cross. Furthermore, it is undisputed that Blue Cross has not threatened to cancel any contracts but rather has continuously offered to enter into the 1971 and 1974 uniform cost contracts with plaintiffs.[15]

Frankford Hospital asserts that the provisions in Blue Cross subscriber contracts which set the rates of reimbursement for services received from non-member hospitals are "coercive." The district and the circuit court considered virtually the identical argument in *Travelers, supra*, and reached the conclusion:

> "[T]he economic inducements which made the Blue Cross contract acceptable to hospitals did not

15. We note, however, that Frankford Hospital contends that Blue Cross has used its existing contractual relationships with the hospitals by intentionally withholding large sums of money which it owes to the hospitals in order to coerce them into signing a new contract.

amount to 'coercion'." (footnote omitted) 481 F.2d at 84.[16]

In *Doctors Hospital v. Blue Cross of Greater Philadelphia, supra*, the court rejected the plaintiff's claim that Blue Cross committed an act of boycott, coercion or intimidation by placing an advertisement in a newspaper which informed the public of the date at which Doctors Hospital would no longer be a Blue Cross member hospital. After certain DVHC hospitals became non-member hospitals on or about September 1, 1974, Blue Cross took steps to notify its subscribers of the names of those hospitals which were continuing to provide member benefits to all subscribers. These steps included the running of newspaper notices. Copies of these advertisements are in the record.[17] None of them is any more coercive to non-member hospitals than the inoffensive advertisement considered in *Doctors Hospital*. Even without this precedent, we would have to conclude that these notices were not only non-coercive within the meaning of section 1013(b) but that it was a responsible business decision to communicate to subscribers the information contained therein.

We will now discuss the allegations of plaintiff which do not have direct corollaries in *Travelers* and *Doctors Hospital*. First, we consider plaintiff's attempt to give a factual basis to its boycott theory. Assuming *arguendo*, that the term, boycott, in section 1013(b) extends to boycotts of persons other than insurance companies and in-

16. The omitted footnote in the above quoted passage stated,

"If a hospital refused to agree to the contract, Blue Cross would reimburse the hospital on a per diem basis at an amount insufficient to cover the hospital's costs. A hospital would have to make up any deficiency by charging the patient directly. We note that this procedure is typical of the indemnification plans offered by private insurance companies."

17. Exhibit P, Q and U to Affidavit of Bruce Taylor.

surance agents,[18] Frankford Hospital still has not created a triable issue of material fact as to its allegation that Blue Cross has conspired with others or otherwise conducted a boycott of non-member hospitals. Frankford Hospital contends that the defendant's main boycott device is its subscriber contracts, which provided that subscribers who are treated in non-member hospitals receive indemnity from Blue Cross in amounts less than the full charges for those services. The argument is that the differential diverts Blue Cross subscribers away from member hospitals and therefore by contracting with hospitals for services Blue Cross is boycotting all hospitals with which it does not contract. Plaintiff also alleges that the defendant has fueled the boycott by running newspaper advertisements that urge subscribers (and, incidentally, the general public) to stay away from non-member hospitals, and by conspiring with union officials to exhort union member subscribers from patronizing non-member hospitals. As discussed above *Travelers* and *Doctors Hospital* have disposed of any notion that the terms of Blue Cross indemnity agreements in subscriber contracts and/or newspaper advertisements which Blue Cross has run constitute prohibited boycotts. As to the allegation of a Blue Cross-union conspiracy, Frankford Hospital has to rest much of its argument on a leaflet issued by Local 834 of the United Auto Workers which stated, *inter alia*,

> "[A]gain, we ask you, if at all possible please stay out of the non-participating hospitals."

There is no evidence that Blue Cross either had prior knowledge that this statement would be made or that it encouraged or counseled the making of such a statement. The uncontradicted depositions of Francis J. McGuire, President, United Automobile Workers Local No. 834, and of Cecil V. Mullen, President, International Brotherhood

18. *But see*, Meicler, *supra*, and Addrisi, *supra*.

of Electrical Workers Local Union No. 1241, make clear that the leaders of these locals acted at their own initiative to try to protect their members from suffering unexpected financial hardships as a result of going to non-member hospitals. They sought information from Blue Cross in order to advise their members; Blue Cross representatives gave them basic information about coverage under the particular union contracts. On one occasion, a Blue Cross representative said that a subscriber who is treated in a non-member hospital could anticipate being asked to pay his or her bill before checking out. Mr. Mullen volunteered the information that a protest letter he wrote to non-member hospitals contained mistaken assertions. He had made some hasty conclusions based on what he was told by the Blue Cross representative, and based on unreliable information from other sources.[19] Similarly, the comments Mr. McGuire addressed to union members (and are objected to by Frankford Hospital) were based on his own ideas and information.[20]

In conclusion, each of the alleged elements of the "boycott" lacks a factual or a legal basis, if not both.

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19. The following exchange in the Mullen deposition illustrates the small role played by Blue Cross representatives:

> "By Mr. Bogus [plaintiff's counsel]: Mr. Mullen, did you have occasion to discuss this matter with any one else at Blue Cross other than Mr. Gannon?
>
> Mr. Mullen: No, I have a very hard time getting anyone at Blue Cross to talk to me." Deposition p. 14.

20. "Mr Bogus: Did anyone at Blue Cross tell you that non-participating hospitals were likely to harrass or pester your members? [Objected to by Blue Cross counsel]
Mr. McGuire: No. The hospitals did it, though. The hospitals have did it. They have harrassed and pestered our members.
Q: Have you discussed that problem with anyone at Blue Cross?
A: To the point where, you know what's happening, has there been anything done through negotiations or stuff like that." McGuire Deposition p. 9.

Second, Frankford Hospital alleges that Blue Cross has failed to negotiate with the hospitals in good faith. We fail to see how this allegation, even if true, would activate section 1013(b). Even if we assume that Blue Cross has been able to adhere to unreasonable negotiating positions because of its dominance in the health insurance market, that would take the plaintiff no further than stating an element of a cause of action under the Sherman Act. But the Sherman Act is irrelevant until plaintiff can carry its burden of showing that the McCarran-Ferguson Act does not apply, and the allegation of bad faith negotiations does not prove that point. In any event, we do not think the plaintiff has established a triable question of fact on the good faith of Blue Cross negotiations in the face of the approval by the Insurance Department of the 1971 and 1974 agreements, and in the face of the Commonwealth's enactment of Act 94. Moreover, the participation of the insurance department in the negotiation of hospital contracts is unabated and so long as this active regulation continues it is the province of the commissioner to rule on the good faith or bad faith of the negotiating parties.[21]

There are some remaining allegations of coercion. Plaintiff says Blue Cross has withheld information from non-member hospitals about the benefits that Blue Cross subscriber patients are entitled to; that Blue Cross has refused to honor assignments of benefit agreements which would entitle non-member hospitals to be paid directly by Blue Cross; that Blue Cross has refused to adjust interim rates of reimbursements to hospitals, as required by existing contract; and that Blue Cross has otherwise "systematically ignored and abused clear legal rights of the hospitals." At least two of these alleged actions are the subject matter of state court contract actions and a third has resulted in a settlement. Even if these grievances could support causes of action under state law, and even if they

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21. See *supra*, at p. 7.

might be unreasonable restraints of trade if that question were ever reached under section 1 and 2 of the Sherman Act, they do not have any bearing on the McCarran-Ferguson Act exception, 15 U.S.C. §1013(b).

We conclude that judgment must be entered for the defendant on the antitrust claims alleged in the complaint. The subject of this action is the business of insurance and it is being aggressively regulated by the Commonwealth of Pennsylvania. The plaintiff has failed to make a preliminary factual showing that it might, at trial, prove that this case comes under the exception to the McCarran-Ferguson Act's general exemption of regulated insurance activities from antitrust scrutiny. Furthermore, because judgment will be entered against plaintiff on its federal claims (which conferred jurisdiction on this court) prior to trial, we decline to exercise pendent jurisdiction over its state law claims. *United Mine Worker v. Gibbs*, 383 U.S. 715, 726 (1966).[22]

/s/

Clarence C. Newcomer, *J.*

22. In declining to exercise pendent jurisdiction we have also considered that it is extremely unlikely that we would ever decide the merits of the state law claims in plaintiff's favor. Only a novel state law argument could defeat the otherwise obvious conclusion that Pennsylvania common law doctrines of unfair competition have been preempted by the statutes establishing nonprofit hospital plans and providing for their regulation; and by Act 94. However, before we would base a decision on a novel state law claim we would abstain so that that decision could be made, if at all, in the state courts. Thus, had we exercised pendent jurisdiction the best result the plaintiff could have expected would have been for the court to abstain. Thus it is made no worse off by our failure to exercise pendent jurisdiction.

IN THE

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action

No. 74-2281

FRANKFORD HOSPITAL

v.

BLUE CROSS OF GREATER PHILADELPHIA

Order

AND NOW, to wit, this 8th day of June, 1976, upon consideration of the defendant's motion for summary judgment, and for the reasons stated in the accompanying Memorandum, it is hereby Ordered that said motion is GRANTED.

Judgment shall be entered in favor of defendant Blue Cross of Greater Philadelphia and against plaintiff, Frankford Hospital, on Counts 1, 2, 3 and 5 of the Complaint.

It is further Ordered that Counts 4 and 6 of the Complaint are DISMISSED.

AND IT IS SO ORDERED.

/s/

Clarence C. Newcomer, *J.*

IN THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 76-2049

FRANKFORD HOSPITAL, *Appellant*
v.
BLUE CROSS OF GREATER PHILADELPHIA

Appeal from the United States District Court
for the Eastern District of Pennsylvania
(D. C. Civil No. 74-2281)

Argued April 1, 1977

Before: SEITZ, *Chief Judge*, and ALDISERT and HUNTER, *Circuit Judges*.

SAMUEL P. LAVINE, ESQ.
CARL T. BOGUS, ESQ.
STEINBERG, GREENSTEIN, GORELICK & PRICE
818 Widener Building
1339 Chestnut Street
Philadelphia, Pennsylvania 19107
Counsel For Appellant
MILES W. KIRKPATRICK, ESQ.
RAYMOND T. CULLEN, JR., ESQ.
STEPHEN W. ARMSTRONG, ESQ.
2100 The Fidelity Building
123 South Broad Street
Philadelphia, Pennsylvania 19109
Of Counsel
Morgan, Lewis & Bockius
Counsel For Blue Cross Of Greater Philadelphia
JAMES H. STEWART, JR., ESQ.
NAUMAN, SMITH, SHISSLER & HALL
Six North Third Street
P. O. Box 840
Harrisburg, Pennsylvania 17108
Counsel For The Hospital Association of Pennsylvania

Opinion of the Court
(Filed May 2, 1977)

Per Curiam

This action was commenced by Frankford Hospital against Blue Cross alleging violations of §§ 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2, and asserting a pendant state claim under Pennsylvania common law. After certifying Frankford as a class representative for purposes of injunctive relief, and after extensive discovery, the district court granted Blue Cross' motion for summary judgment on the federal claims and declined to exercise jurisdiction over the state law claim. Frankford appealed.

The narrative or historical facts are not in dispute. The issue is purely one of law: whether Blue Cross' conduct is exempted from the Sherman Act by the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq*. As the district court correctly concluded, that issue is settled by *Travelers Insurance Co. v. Blue Cross*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1083 (1973), and by *Doctors, Inc. v. Blue Cross*, — F.2d — (3d Cir. 1976). Those cases establish that the "business of insurance" provision[1] of the McCarran-Ferguson Act exempts Blue Cross' conduct here from the coverage of the Sherman Act unless "boycott, coercion, or intimidation" is demonstrated which would remove the McCarran-Ferguson Act exemption.[2] We agree with the district court that none of these elements was present here.

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1. 15 U.S.C. §1012(b) provides:

   . . . the Sherman Act . . . shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

2. 15 U.S.C. §1013(b) provides:

   Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

Accordingly, we will affirm the judgment of the district court on the grounds that the McCarran-Ferguson Act exemption applies and that there was no boycott, coercion, or intimidation to remove the exemption. We will also affirm the district court's refusal to exercise jurisdiction over the state law claim.

The judgment of the district court will be affirmed.

TO THE CLERK:

Please file the foregoing opinion.

_____

Circuit Judge

IN THE

UNITED STATES COURT OF APPEALS

FOR THE THIRD CIRCUIT

No. 76-2049

FRANKFORD HOSPITAL, *Appellant*

v.

BLUE CROSS OF GREATER PHILADELPHIA

(D. C. Civil No. 74-2281)

On Appeal From the United States District Court For the Eastern District of Pennsylvania

Present:

SEITZ, *Chief Judge* and ALDISERT and HUNTER, *Circuit Judges*

JUDGMENT

This cause came on to be heard on the record from the United States District Court for the Eastern District of Pennsylvania and was argued by counsel April 1, 1977.

On consideration whereof, it is now here ordered and adjudged by this Court that the judgment of the said District Court, filed June 9, 1976, be, and the same is hereby affirmed in accordance with the opinion of this Court. Costs taxed against appellant.

ATTEST:

_____

Clerk

May 2, 1977

McCarran-Ferguson Act (15 U.S.C. §1011 et seq.)

§ 1011. Declaration of policy

Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

§ 1012. Regulation by State law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

§ 1013. Suspension until June 30, 1948, of application of certain Federal laws; Sherman Antitrust Act applicable to agreements to, or acts of, boycott, coercion, or intimidation

(a) Until June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of

October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, and the Act of June 19, 1936, known as the Robinson-Patman Anti-Discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

(b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

§ 1014. Applicability of National Labor Relations Act and Fair Labor Standards Act of 1938

Nothing contained in this chapter shall be construed to affect in any manner the application to the business of insurance of the Act of July 5, 1935, as amended, known as the National Labor Relations Act, or the Act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938, or the Act of June 5, 1920, known as the Merchant Marine Act, 1920.

§ 1015. Definition of "State"

As used in this chapter, the term "State" includes the several States, Alaska, Hawaii, Puerto Rico, Guam, and the District of Columbia.